GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

ORLENE HAWKS
DIRECTOR

October 6, 2022

Carol Del Raso
Riley's Grove Assisted Living
9481 Pentatech
Zeeland, MI 49464

RE: License #: AH700396224
Investigation #: 2022A1028055
Riley's Grove Assisted Living

Dear Ms. Del Raso:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action. Please review the enclosed documentation for accuracy and contact me with any questions. In the event I am not available, and you need to speak to someone immediately, please contact the local office at (616) 356-0100.

Sincerely
Julie Viviano, Licensing Staff
Bureau of Community and Health Systems
Unit 13, 7th Floor
350 Ottawa, N.W.
Grand Rapids, MI 49503
Cell (616) 204-4300

MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT

I. IDENTIFYING INFORMATION

License #:	AH700396224
Investigation #:	2022A1028055
Complaint Receipt Date:	06/27/2022
Investigation Initiation Date:	06/27/2022
Report Due Date:	08/27/2022
Licensee Name:	Riley's Grove Assisted Living, LLC
Licensee Address:	Ste 200 3196 Kraft Ave. SE Grand Rapids, MI 49512
Licensee Telephone #:	(616) 748-0565
Administrator:	Amanda Mlejnek
Authorized Representative:	Carol Del Raso
Name of Facility:	Riley's Grove Assisted Living
Facility Address:	9481 Pentatech Zeeland, MI 49464
Facility Telephone #:	(616) 748-0565
Original Issuance Date:	11/16/2020
License **Status:**	REGULAR
Effective Date:	05/16/2022
Expiration Date:	05/15/2023
Capacity:	70

Program Type:	AGED ALZHEIMERS

II. ALLEGATION(S)

	Violation Established?
Resident A assaulted Resident B on 6/10/22 and again on 6/12/22 due to lack of staff supervision and protection of Resident B.	Yes
Additional Findings	Yes

III. METHODOLOGY

06/23/2022	Special Investigation Intake 2022A1028055
06/23/2022	Special Investigation Initiated - Letter 2022A1028055
06/27/2022	APS Referral APS referral emailed to Centralized Intake.
07/11/2022	Inspection Completed On-site
07/11/2022	Contact - Face to Face Interviewed Admin/Amanda Mlejnek at the facility.
07/11/2022	Contact - Face to Face Interviewed Employee A at the facility.
07/11/2022	Contact - Face to Face Interviewed Employee B at the facility.
07/11/2022	Contact - Face to Face Interviewed Employee C at the facility.
07/11/2022	Contact - Face to Face Observed Resident A at the facility.
07/11/2022	Contact - Face to Face Observed Resident B at the facility.
10/06/2022	Exit Interview

ALLEGATION:

Resident A assaulted Resident B on 6/10/22 and again on 6/12/22 due to lack of staff supervision and protection of Resident B.

INVESTIGATION:

On 6/23/2022, the Bureau opened an investigation due to an incident report from the facility prompting further investigation.

On 6/23/2022, an Adult Protective Services (APS) referral was made to Centralized Intake.

On 7/11/2022, I interviewed facility administrator, Amanda Mljenek, at the facility. Ms. Mlejnek reported Resident A and Resident B resided in the memory care unit of the facility when the incidents occurred. Resident A and Resident B have impaired cognition, however, have enjoyed each other's company and often like to sit next to each other in the common areas of the memory care unit. On 6/10/22, Resident A was found in the common area with [their] hand up Resident B's shirt. A care staff member intervened with Resident A and Resident B being separated and assessed. Resident A and Resident B were monitored for the rest of the day, with both requiring redirection from staff to remain separate. Resident A was sent to the hospital later in the day for a psych evaluation as well, but later returned to the facility the same day with no new orders. Ms. Mlejnek reported the facility was looking for in-patient psych hospital placement for Resident A, but there were none at that time, so Resident A's spouse came to the facility on 6/10/22 and provided 1:1 supervision until further options could be explored. However, on 6/12/22, Resident A was discovered by a care staff member with [their] hands down Resident B's pants. Care staff asked Resident A to not touch anyone and both residents were separated. Ms. Mlejnek reported Resident A and Resident B's authorized representatives and physicians were contacted and conferenced with due to both incidents to determine the best course of action for both residents going forward. Resident A was eventually moved to a separate apartment outside of the memory care unit and Resident A's spouse is no longer providing 1:1 supervision due to being moved out of the memory care unit. Ms. Mlejnek reported Resident A's spouse scheduled an upcoming psych appointment for Resident A to determine appropriate care and interventions for Resident A due to a recent increase in inappropriate behaviors. Ms. Mlejnek reported Resident A and Resident B's service plans were updated to include hourly checks to ensure appropriate supervision. However, Resident A is allowed to return to the memory care unit to visit with other residents but is supervised by staff and/or [their] spouse to ensure Resident A and Resident B are kept separated from each other. Ms. Mlejnek provided me a copy of Resident A and Resident B's service plan with record notes for my review.

On 7/11/22, I interviewed Employee A at the facility. Employee A reported Resident A and Resident B are friends and often enjoyed each other's company in the common areas of the memory care unit, but Resident A continues to demonstrate an increase with inappropriate behavior. Employee A reported an incident occurred on 6/10/22 and again on 6/12/22 in which Resident A was discovered touching Resident B inappropriately. Employee A reported Resident A and Resident B do not have any memory of either incident. Care staff separated and assessed each resident after both incidents with Resident A being sent to the hospital after the first incident on 6/10/22. Employee A reported Resident A returned with no new orders then, but Resident A's spouse came to the facility and provided 1:1 supervision afterwards. Employee A reported after the second incident on 6/12/22, Resident A was eventually moved to a separate apartment outside of the memory care unit in the facility, but "[Resident A] has returned to the [memory care] unit to visit another resident since moving to [their] new apartment on the other side of the building." Employee A reported Resident A and Resident B are monitored by care staff if there is potential for them to be in the same area.

On 7/11/22, I interviewed Employee B at the facility. Employee B reported Resident A and Resident B have impaired cognition and often seek out engagement from others. Resident A was discovered on 6/10/22 and 6/12/22 inappropriately touching Resident B. The residents were separated and monitored further with Resident A being sent to the hospital and returning shortly afterwards with no new orders. Resident A's spouse provided 1:1 supervision after Resident A returned from the hospital on 6/10/22 but was not present during the second incident on 6/12/22. Employee B reported Resident A continues to demonstrate inappropriate behavior despite being moved from the memory care unit of the facility. Resident A's spouse is seeking further evaluation from Resident A's physician to assist the facility with addressing Resident A's inappropriate behaviors. Employee B reported Resident A continues to visit the memory care unit "to see [their] friends" but care staff supervise the visits.

On 7/11/22, I interviewed Employee C at the facility. Employee C's statements are consistent with Ms. Mlejnek's, Employee A's and Employee B's statements concerning the incidents that occurred on 6/10/22 and 6/12/22 between Resident A and Resident B. Employee C reported Resident B wanders outside of the memory care unit as allowed and often has to be redirected back to the memory care unit to prevent "running into [Resident A]." Employee C reported Resident B seeks out engagement with others. Employee C also confirmed Resident A continues to visit the memory care unit as well with care staff supervising.

On 7/11/22, I completed an inspection of the facility and observed Resident A in [their] apartment in the assisted living area. Resident A was in bed during the observation.

I also completed an inspection in the memory care unit and observed Resident B, who was sitting at a table independently. Resident B engaged in conversation with care staff but demonstrated impaired cognition during the observation.

On 7/12/22, I reviewed Resident A's service plan which is last dated 4/29/22. The review revealed the following:

- *Requires regular prompting due to confusion and disorientation.*
- *Requires assistance with following simple directions.*
- *Requires hourly monitoring.*
- *Does not wander* but the frequency is listed as daily.
- *Exhibits resistive/uncooperative behaviors occasionally but less than daily. Resident has resisted assistance. Has kicked staff. Can be redirected safely.*
- *Does not exhibit sexual distressing behaviors. [Resident A] enjoys being nude. Staff and visitors to be aware.*
- *Requires encouragement and reminders for life enrichment and socialization activities daily.*
- Requires assistance with grooming, dressing, showering, toileting, and staff assist with medication administration.
- Transfers and ambulates independently.
- Independent with dining but *exhibits dining behaviors such as licking plate, obtaining extra sugar or juice if left out, pokes at staff with utensils asking for more.*

Review of Resident A's record notes from June 2022 revealed the following:

- Resident A returned from the hospital on 6/11/22 with no new orders.
- On 6/12/22, Resident A engaged in inappropriate behavior in room in the memory care unit with friend present.
- On 6/13/22, Resident A was sent back to hospital for *inpatient therapy and med reconciliation.*
- Resident returned to community on 6/23/22.

I also reviewed Resident B's service plan which was last dated 3/10/22. The review revealed the following:

- *Has occasional confusion and some difficulty recalling details. Needs occasional prompting or orientation.*
- *Communicates independently. Able to follow directions.*
- *Has good safety awareness and may be outside on campus grounds unsupervised but needs supervision to leave campus.*
- *Requires baseline in monitoring at change of each shift, mid-day meal and once per mid third shift.*
- *Wanders in public areas but not intrusive. Does not try to leave community.*
- *Does not exhibit present or past resistive/uncooperative behavioral issues.*
- *Does not exhibit verbal disruptive behaviors, social disruptive behaviors, or sexual distressing behaviors.*

- *Self-directed with life enrichment and socialization activities.*
- Requires set up with grooming, dressing, and showering.
- Independent with toileting.
- Transfers and ambulates independently.
- Staff manages medication administration.
- Independent with dining.

Review of Resident B's record notes from June 2022 revealed the following:

- Resident B's family was notified in person on 6/12/22 of incident with Resident A inappropriately touching Resident B.
- On 6/13/22, Resident B asked to sit on another resident's lap due to no chairs being available in sitting area.
- On 6/14/22, Resident B demonstrated increased forgetfulness with meals and was asking for food and beverages. *[Resident B] forgetting when [they are] eating and will immediately come back for more.*
- On 6/23/22, Resident *B wandering outside [in enclosed area] and in the halls frequently.* Increased hourly supervision checks implemented. *Any interaction with [Resident A] needs to be monitored very closely.*
- On 6/25/22, Resident B demonstrated an increase with inattention to activity.
- On 6/25/22, Resident B engaged in a conversation with another resident and asked the resident *"Would you like to kiss my cheek?" [Resident B] told to stop flirting.*
- On 6/25/22, Resident B demonstrated anger after shower and became worried about clothing. Resident B redirected multiple times and shown where clothing was.
- On 7/4/22, Resident B *was up and about in and out of doors all day.* Demonstrated confusion throughout the day and agitation beginning at 4:00pm. Care staff assisted with medications to address agitation.

APPLICABLE RULE	
R 325.1921	**Governing bodies, administrators, and supervisors.**
	(1) The owner, operator, and governing body of a home shall do all of the following: **(b) Assure that the home maintains an organized program to provide room and board, protection, supervision, assistance, and supervised personal care for its residents.**
For Reference: R 325.1901	**Definitions**
	(16) "Protection" means the continual responsibility of the home to take reasonable action to ensure the health, safety,

	and well-being of a resident as indicated in the resident's service plan, including protection from physical harm, humiliation, intimidation, and social, moral, financial, and personal exploitation while on the premises, while under the supervision of the home or an agent or employee of the home, or when the resident's service plan states that the resident needs continuous supervision.
ANALYSIS:	On 6/10/22, Resident A inappropriately touched Resident B. The residents were separated and provided increased supervision until Resident A was sent to the hospital for evaluation later in the day. Resident A returned the same day with no new orders. One to one supervision was provided by Resident A's spouse on 6/10/22 due to the incident, however, it cannot be determined the extent or length of one to one supervision that was provided by Resident A's spouse and/or family. Due to Resident A and Resident B not being provided further appropriate supervision or protection by care staff after the incident on 6/10/22, a second incident of inappropriate behavior occurred with Resident A and Resident B on 6/12/22. Despite facility staff interviews, it cannot be determined the extent or length of supervision care staff provided Resident A and/or Resident B after the incident on 6/10/22. Also, review of documentation reveals no evidence care staff were educated on appropriate redirection or interventions for either resident, or that care staff were instructed to provide increased supervision to either resident after the first incident occurred on 6/10/22 to try to prevent reoccurrence.
CONCLUSION:	**VIOLATION ESTABLISHED**

ADDITIONAL FINDINGS:

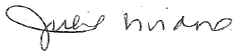
APPLICABLE RULE	
R 325.1922	**Admission and retention of residents.**
	(5) A home shall update each resident's service plan at least annually or if there is a significant change in the resident's care needs. Changes shall be communicated to the resident and his or her authorized representative, if any.

ANALYSIS:	Review of Resident A and Resident B's service plans reveal no interventions were added to either resident's service plans to deter inappropriate behavior and/or prevent a reoccurrence despite the incidents that occurred on 6/10/22 and again on 6/12/22. Also, Resident A's service plan does not reflect the move to assisted living from the memory care unit or the need for additional supervision while residing in assisted living due to an increase in inappropriate behavior with residents and care staff.
CONCLUSION:	**VIOLATION ESTABLISHED**

APPLICABLE RULE	
R 325.1924	**Reporting of incidents, accidents, elopement.**
	(3) The home shall report an incident/accident to the department within 48 hours of the occurrence. The incident or accident shall be immediately reported verbally or in writing to the resident's authorized representative, if any, and the resident's physician.
ANALYSIS:	While there is evidence of facility charting for Resident A, the department was not notified of Resident A's absence from the facility due to recent hospitalization. Review of facility department file reveals no report was submitted for Resident A's recent hospitalization from 6/13/22 to 6/23/22.
CONCLUSION:	**VIOLATION ESTABLISHED**

IV. RECOMMENDATION

Contingent upon an acceptable corrective action plan, I recommend the status of this license remain unchanged.



7/13/22

Julie Viviano Date
Licensing Staff

Approved By:

10/05/2022

Andrea L. Moore, Manager Date
Long-Term-Care State Licensing Section